PRINTED: 08/12/2009 FORM APPROVED OMB NO. 0938-0391

| | | | A. BUIL | DING | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 295044 | B. WIN | | | C 04/21/2009 | | | |
| | ROVIDER OR SUPPLIER | | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434 | 04/2 | 1/2009 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | S | F | 000 | | | | | |
| F 157 SS=G | This Statement of Dethe result of a Medica which was completed were sampled. The survey was cond CFR Chapter IV Part States and Long Ten The following complaint #NV21850 157, 309, 325, 441) The findings and conby the Health Division prohibiting any criminations or other claim available to any party state, or local laws. The following regulation identified. 483.10(b)(11) NOTIFIED A facility must immediate consult with the residence or an interested family accident involving the injury and has the position of the complete of the results of the consult with the residuation of the consult with the r | eficiencies was generated as are complaint investigation d on 4/21/09. Seven records ducted in accordance with 42 at 483 Requirements for m Care Facilities. Solution of any investigation in shall not be construed as hall or civil investigations, has for relief that may be younder applicable federal, Sory deficiencies were a created and if ident's legal representative ly member when there is an are resident which results in intential for requiring physician | | 157 | | | | | |
| LABORATORY | physical, mental, or p deterioration in healt status in either life th clinical complications significantly (i.e., a no existing form of treat | cant change in the resident's psychosocial status (i.e., a h, mental, or psychosocial reatening conditions or s); a need to alter treatment eed to discontinue an ment due to adverse | | | TITLE | | (X6) DATE | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
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| | | 295044 | B. WIN | G | | C 04/21/2009 | | | |
| | ROVIDER OR SUPPLIER | IEVADA | • | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 50 BARING BLVD PARKS, NV 89434 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 157 | treatment); or a decise the resident from the §483.12(a). The facility must also and, if known, the resor interested family mechange in room or rospecified in §483.15 resident rights under regulations as specifithis section. The facility must record the address and phore legal representative of | commence a new form of sion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative member when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of ord and periodically update me number of the resident's or interested family member. This not met as evidenced and record review, the facility ysician of changes in manner for 2 of 7 sampled sive, coronary gestive heart failure, atrial and hypothyroidism. The sentative had been at dialysis for the resident in a years, without the resident | F | 157 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
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| | | 295044 | B. WIN | | | C 04/21/2009 | | | |
| | ROVIDER OR SUPPLIER | IEVADA | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 50 BARING BLVD PARKS, NV 89434 | , 0 112 | | | |
| (X4) ID PREFIX TAG | | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 157 | Continued From page | e 2 | F | 157 | | | | | |
| | resident assessment 4. Cognitive skills for dated 1/22/09, that sl been independent in "decisions being cons Record review reveal summary dated 1/22/ checked: "Alert, mem staff names/faces, th decision making - ind summary dated 1/28/ recall - staff names/ f home; decision makin Record review reveal note dated 1/19/09 th peritoneal catheter." Record review reveal been transferred to a 3/7/09, for coughing a On 4/6/09 at 10:30 A was interviewed and the facility contacted notify him that the res refusing to take his m reported that the resi progressively worse of saturation of 74% and in the morning on 3/7 nurse had stated to h condition had deterio asked him if he would hospital. The resider | ed a weekly nursing 109, with the following boxes 109, with the following boxes 109, recall - current season, 109, recall - current season, 109, read: Alert, memory 109, r | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | ` IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING | | | С | |
| | | 295044 | B. WING | | 04/21/2009 | | |
| | ROVIDER OR SUPPLIER | EVADA | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | | | |
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| F 157 | that followed the residerenal failure. He ther not aware that the residence of the residence of the therm of aware that the residence of the therm of the hospital to send the facility emergency dereportedly called a did determine whether or the hospital. The resident the nurse then can hospital to send the reson-in-law reported the resident to the closes reportedly passed awareview revealed a death the resident had of death was peritonit. Review of Resident # entries made into the the following: 2/25/09 - the psychiat resident and docume "underhydrated?" 2/26/09 - "Patient confluids Increased and distension" 2/27/09 - "the resident and counder the following: 2/25/09 - "Resident agand oriented to self, sand oxygen saturation saturation of the saturation of the self, sand oxygen saturation agand oriented to self, sand oxygen saturation" | dent for treatment of his a reported that the nurse was sident had a nephrologist dent's care. The nurse then obrologist. The resident's orted that the nurse called was directed by the the resident to an acute care partment. The nurse then alysis nurse consultant to not to send the resident to ident's son-in-law reported alled back to ask what esident to, and the nat he told her to send the thospital. The resident ray on 3/11/09. Record ath certificate that reported expired and that the cause tis. 2's medical record revealed nurse's notes that contained trist did a consult with the need that the resident was attinues to not eat takes some pical rate, abdominal | F 157 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 295044 | B. WIN | IG | | 1 | C 1/2009 |
| | ROVIDER OR SUPPLIER | | I | 19 | REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434 | 1 04/2 | 1/2009 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 157 | evaluation." No evidence was four contacted the physicial Resident #2's condition evidence was found the physician had been as impression on 2/25/0. Resident #3 Resident #3 Resident #3 was admaged and sease requiring permellitus and peripheraresident was dependented and sease and s | and that the nursing staff had an related to a change in on prior to 3/7/09. No hat the resident's primary ware of the psychiatrist's 9. Initted to the facility on es including end-stage renal itoneal dialysis, diabetes al vascular disease. The ent for all peritoneal dialysis ed a document titled "that was completed upon ion on 3/18/09 that read: s: temperature - 98.0 ssessment: independent in decision is being e." on admission or problems documented and acute care facility on ature of 100.3 Fahrenheit. | F | 157 | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | A. BUILDING | | | С | |
| | 295044 | B. WING | | 04 | /21/2009 | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEV | /ADA | 1950 | T ADDRESS, CITY, STATE, ZIP COI D BARING BLVD ARKS, NV 89434 | • | | |
| PREFIX (EACH DEFICIENCY M | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| Found medications in his shift. Calling for help comachine keeps beeping. Record review revealed 3/24/09 night shift: temps 3/26/09 night shift: temps 4/4/09 - 3/26/09: "Patientermittentlybut puts 4 exercises throughout without trying to regurgi 3/27/09 - 4/2/09: "Active five treatments due to Record review revealed physician had been made condition changes prior resident was transferred. The Director of Nursing on 4/9/09 at 11:20 AM, and symptoms to look for peritonitis included: Expression in the abdomen, nausea of shoulder pain, elevated. | r pain in left shoulder." cult today. Not compliant. is bed. Restless early constantly. Dialysis g." If the following: cerature - 99.4 Fahrenheit cerature - 99.1 Fahrenheit cerature - 99.1 Fahrenheit derature - | F 157 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | IEVADA | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | 04/2 | 172003 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 157 | Continued From page | e 6 | F | 157 | | | | |
| | and reported that Resto the acute care facilidagnosis of peritonitian Review of Resident # revealed that on 4/5/0 department physician "Assessment: 1. Sepsis, source per associated pneumonia Emergency Department White blood cell counfor pneumonia." | s. 3's acute care record 99, the emergency 1 recorded: itonitis versus health care ia. | | | | | | |
| F 309 SS=G | provide the necessary or maintain the higher mental, and psychosological accordance with the control and plan of care. This REQUIREMENT by: Based on interview, repolicy and procedure facility failed to provide | eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced ecord review, and review of and industry standards, the le necessary care and eritoneal dialysis for 2 of 7 | F | 309 | | | | |

| A. BUILDING | |
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| | ; |
| 295044 B. WING 04/21/2 | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA STREET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 309 Continued From page 7 Findings include: Resident #2 Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection. Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. "Cognitive skills for daily decision making," dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable." Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: "Alert, memory recall - current season, staff names/faces, that he is in a nursing home; decision making - independent." A weekly nursing summary dated 1/28/09, read: "Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." A weekly nursing summary dated 1/28/09 read: "Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." A weekly nursing summary dated 1/28/09 read: "Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter." Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia. On 4/6/09 at 10:30 AM, Resident #2's son-in-law | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | OVIDER OR SUPPLIER | IEVADA | . | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434 | 04/2 | 172003 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| F 309 | the facility contacted notify him that the reservising to take his mareported that the residual progressively worse of saturation of 74% and in the morning on 3/7 nurse had stated to homogital. The resident that he directed then that follows the resident failure. He then reposon-in-law further rephim to report that she nephrologist to send the nephrologist to send facility emergency de reportedly called a dia determine whether or the hospital. The rest that the nurse then can hospital to send the relaw reported that he to the closest hospital passed away on 3/11 a death certificate that had expired and that peritonitis. Review of Resident # entries made into the the following: 2/25/09 - the psychiat | reported that a nurse from him on 3/6/09 at 8:00 AM, to sident was coughing and ledications. The son-in-law dent had become overnight, with an oxygen of the nurse had called again 1/09. He reported that the lim that the resident's rated and that the nurse had at like her to send him to the like her to send him to the like son-in-law then reported lurse to call the nephrologist lent for treatment of his renal larted that the nurse was not like an ephrologist. The nurse then obrologist. The resident's orted that the nurse called | F | 309 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTF AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SUR COMPLETE | | | | |
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| | | 295044 | B. WIN | IG | | 04/2 | C 1/ 2009 |
| | ROVIDER OR SUPPLIER | IEVADA | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | G #12 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| F 309 | fluids Increased ap distension" 2/27/09 - "the resident temperature" 3/6/09 - "Resident ag chest x-ray ordered to loss 31 pounds" 3/7/09 - "Resident ag and oriented to self, sand oxygen saturatio labored breathing; se evaluation." No evidence was four contacted the physicial Resident #2's condition evidence was found to physician had been a impression on 2/25/00. Record review reveal #2 that was developed therapy. The care planguage "Goals: will not expense secondary to dialysis Approach: 1. Resident will be trained to the proper secondary to dialysis approach: 2. Resident will be proper to the proper secondary to dialysis approach: 3. Avoid taking blood injections over shunted to the proper secondary to dialysis treatment days. 2. Resident will be proper secondary to dialysis approach: 3. Avoid taking blood injections over shunted to the proper secondary to dialysis treatment days. 3. Avoid taking blood injections over shunted to the proper secondary to dialysis treatment days. 4. Resident will be proper secondary to dialysis treatment days. 5. After dialysis treatment days reactions to the proper secondary to dialysis treatment days. 6. Record review reveal the proper secondary to dialysis treatment days. 6. Record review reveal the proper secondary to dialysis treatment days. 6. Record review reveal the proper secondary to dialysis treatment days. | attinues to not eat takes some bical rate, abdominal at had an elevated attated; resident coughing, orule out pneumonia; weight bitated, yelling for help; alert skin pale; breathing labored in 74%; skin ash color with an to emergency room for and that the nursing staff had an related to a change in on prior to 3/7/09. No that the resident's primary ware of the psychiatrist's 9. Bed a care plan for Resident and for outpatient dialysis an revealed the following: ience complications for 90 days. Ansported to dialysis center ovided with take out meals if ealtimes. pressures or giving ed arm. ment observe resident for | F | 309 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 295044 | B. WIN | IG | | 1 | C 4/2000 |
| | OVIDER OR SUPPLIER | | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434 | 04/2 | 1/2009 |
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| F 309 | disease requiring per mellitus and periphera resident was dependenceds. Record review reveal "Nursing Assessment Resident #3's admiss "Section 3. Vital Signar Fahrenheit Section 8. Physical A A. Neuro/Cognitive: in making with "decision consistent/reasonable E. Pain: denies pain of J. Gastrointestinal: not Record review reveal been transferred to at 4/4/09, with a temperary Record review reveal notes entries: 3/23/09 - "Has disories 3/24/09 - "Resident very 10 minutes." 3/25/09 - "Keeps on reshoulder pain." 3/28/09 - "Medicated 3/31/09 - "Resident decided | nitted to the facility on es including end-stage renal itoneal dialysis, diabetes al vascular disease. The ent for all peritoneal dialysis ed a document titled that was completed upon ion on 3/18/09 that read: s: temperature - 98.0 ssessment: ndependent in decision as being e." on admission o problems documented" ed that Resident #3 had in acute care facility on ature of 100.3 Fahrenheit. ed the following nurse's entation at times." ery needy, on the call light moaning, complains of for pain in left shoulder." ifficult today. Not compliant. In his bed. Restless early constantly. Dialysis | F | 309 | | | |
| | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 295044 | B. WING | | 044 | C 21/2009 | | |
| | OVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP COL 1950 BARING BLVD SPARKS, NV 89434 | | 21/2009 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 309 | Continued From page | e 11 | F 30 | 09 | | | | |
| | 3/26/09 night shift: ter 4/4/09 night shift: ter Record review reveal the physical therapy of 3/20/09 - 3/26/09: "Pointermittentlybut pure exercises throughout without trying to regure 3/27/09 - 4/2/09: "Act five treatments due to the discount of the physician had been in condition changes provided the properties of Nursion 4/9/09 at 11:20 At and symptoms to loo of peritonitis include: the abdomen, naused shoulder pain, elevate change in level of conditioning of cloudy discount of the properties of the provided that Record review of a properties of the acute care faciliagnosis of peritonitis includes the acute care faciliagnosis of peritonitis of peritonitis includes the acute care faciliagnosis of peritonitis of the peritonitis includes the acute care faciliagnosis of peritonitis includes the acute care faci | mperature - 99.4 Fahrenheit mperature - 99.1 Fahrenheit mperature - 99.1 Fahrenheit meekthe following entries into weekly summary: atient has been ill ts effort towards his but the day and tries his best rgitate onto his caregivers." ively participated in three of o bilateral shoulder pain." led no evidence that the made aware of Resident #3's ior to the day that the red to the acute care facility. Ing (DON) was interviewed M, and reported that signs k for that may be indicative Distension or tenderness of a or vomiting, diarrhea, ed temperature, anxiety, nsciousness, confusion, or alysate. hysician's progress note led: "had vomiting after ewed on 4/9/09 at 11:20 AM, sident #3 had been admitted lity on 4/4/09, with a | | | | | | |
| | Review of Resident # | 3's acute care record | | | | | | |

| STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 295044 | B. WIN | IG_ | | 04/21/2009 | |
| | ROVIDER OR SUPPLIER | EVADA | • | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | | |
| (X4) ID PREFIX TAG | (-, -, -, -, -, -, -, -, -, -, -, -, -, - | | | ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY) | | LD BE | (X5) COMPLETION DATE |
| F 309 | associated pneumonic Emergency Departmed White blood cell coun for pneumonia." Record review reveal an inpatient at the accommendation of the staff Development interviewed on 4/9/09 that almost all of the staff completed training results of the staff provided that the from a local dialysis of facility staff related to the staff provided that the reconstruction of the staff provided that the staff peritoneal dialysis propowder in the gloves peritonitis. When ask be performed using a "no, it is a clean procedured the pool of the pool of the peritoneal dialysis provided t | op, the emergency recorded: itonitis versus health care a. ent Course: it 14,000. X-ray was clear ed that Resident #3 was still ute care facility on 4/20/09. Int Coordinator was at 11:00 AM, and reported registered nurses (RNs) had lated to peritoneal dialysis. facility had a consultant renter come in and train the peritoneal dialysis. Is consultant's training outline mmended that staff not wear experitoneal dialysis M, the dialysis consultant reported that he does not wear gloves during the ocedures because the is a common source of sed if the procedures are to septic technique, he replied redure." at she performs the ocedures on week-days. The does not wear gloves while sed one wear gloves while sed one wear gloves while | F | 309 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 295044 | B. WIN | IG | | 04/21/2009 | | |
| | ROVIDER OR SUPPLIER | IEVADA | ' | 1: | REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434 | , , , | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | (EACH CORRECTIVE ACTION SHOU | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 309 | instructed not to wear inside of the gloves is peritonitis. Record review reveal were wearing gloves dialysis procedures. Review of the facility' revealed a policy and titled: "Nursing Stand Dialysis, Peritoneal (CStandard: 1. The qualified nursi ordered by a physicial requiring peritoneal diality maintain their highest and health. 2. The qualified nursi (corporate) guidelines and health. 2. The qualified nursi (corporate) guidelines and health care ce Acknowledgement of #FFNP006 4. Refer to the Staff EPractice: #24 Compedialysis." "Description: Infection control prace essential to prevent the which often may prevent the staff of the prevent the staff of the staff o | nt Coordinator was rted that the nurses were r gloves because the powder s a common cause of ed no evidence that staff while performing peritoneal s policies and procedures procedure dated 2004, ards of practice, Subject: CAPD) ng staff will provide care as in for patients/residents ialysis that allows them to t practicable level of function ng staff will follow the s. nter will obtain the Resident Informed Consent Form Development Standards of tency for Peritoneal tices and technique are the occurrence of peritonitis tent patients/residents from | F | 309 | | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 295044 | B. WIN | G | | C 04/21/2009 | | |
| | OVIDER OR SUPPLIER | IEVADA | • | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434 | , , , , , | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 309 | to be removed. Dialysis Exchange: C. Wash hands, don gloves. Both licensed mask. N. Don sterile gloves. Review of a peer revi Mid-Atlantic Renal Co "Preventing Bacterial Resistance in Dialysis following: "Strategy 4: Preventic-The Centers for Dise (CDC) recommends when touching patien | erile gloves s needed to determine fluid mask and non-sterile d nurse and patient/resident " ew article published by the palition dated 12/02, titled: Infections and Antimicrobial is Patients," revealed the passe Control and Prevention wearing gloves at all times ts or dialysis equipment to contaminants too small to | F | 309 | | | | |
| F 325 SS=G | resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that thi | s comprehensive ity must ensure that a able parameters of nutritional weight and protein levels, clinical condition | F | 325 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 295044 | B. WIN | | | C 04/21/2009 | |
| | OVIDER OR SUPPLIER | | · | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | 04/2 | 1/2009 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY) | | ILD BE | (X5) COMPLETION DATE |
| F 325 | Continued From page nutritional problem. | e 15 | F | 325 | 5 | | |
| | by: Based on record revie and review of industry | ew, interview, policy review, y standards the facility failed nterventions to prevent a s for 2 of 7 sampled | | | | | |
| | the lower extremities, depression, and Meth | ses including ulcerations of protein calorie malnutrition, | | | | | |
| | inches in height. | : 192 pounds | | | | | |

| 1, / | DENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---------------------|--|-------------------------------|--|--|
| | | A. BUILDING | | С | | |
| | 295044 | B. WING | | 04/21/2009 | | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434 | | | |
| (X4) ID SUMMARY STATEMENT OF DEFINE PREFIX (EACH DEFICIENCY MUST BE PRECE TAG REGULATORY OR LSC IDENTIFYING I | DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION | | |
| F 325 Continued From page 16 2/1/09: 140 pounds Record review revealed that the resibody weight was 190 pounds. Record further revealed that the resident hat pounds, or 26.4% of his usual body 3 month period. Record review revealed a care plan #1 that was not dated. It listed a gowill stabilize at 190 pounds." Interve included: "4 ounces of house suppletimes daily between meals, encoura meals and offer alternate if (intake) 175%, offer snacks per protocol, ice of lunch and dinner, report weight charphysician, dietician, and family." The dietitian was interviewed on 4/9 AM, and reported that Resident #1 her that "he wanted to be at or arour pounds." She further reported that saggressive with the resident's nutritive because she felt that the scale must inaccurate. She reported that she direcommend that the scale be check calibrated. Resident #2 Resident #2 Resident #2 was admitted to the fact 1/15/09 with diagnoses including endisease, failure to thrive, coronary atherosclerosis, congestive heart fait fibrillation, anemia, and hypothyroidiresident's legal representative had be performing peritoneal dialysis for the the community for six years. | for Resident all of "weight entions ement three age intake of less than cream with ange to 10/09 at 11:30 and stated to and 190 she did not get ional care thave been lid not ed or 10/09 at 12 and 10/09 at 12 and 10/09 at 13 and 10/09 at 14 and 10/09 at 14 and 10/09 at 15 and 10/09 at 1 | F 325 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-------------------|---|--|-------------------------------|----------------------------|--|
| | | 295044 | B. WIN | IG | | 1 | C 1/2009 | |
| | ROVIDER OR SUPPLIER | IEVADA | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434 | 04/2 | 172003 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 1 | ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY) | | LD BE | (X5) COMPLETION DATE | |
| F 325 | Record review reveal inches in height. Record review reveal was checked on the form of the following states in height. Record review reveal was checked on the form of the following states in height. Record review reveal was checked on the form of the following states in height. Record review pounds 1/21/09: 188 pounds 1/24/09: 182 pounds 1/25/09: 187 pounds 1/26/09: 183 pounds 1/27/09: 181 pounds 1/27/09: 181 pounds 1/26/09: 176 pounds 1/3/09: 175 pounds 1/3/09: 175 pounds 1/3/09: 175 pounds 1/3/09: 175 pounds 1/3/09: 168.3 | led that Resident #2's weight following dates: Is entry into the nurse's note d: "Resident's weight 159 nds." It is that the resident's usual pounds. Record review the resident had lost 25 his usual body weight over a strist did a consult with umented that the resident with umented that the resident in No evidence was found mary physician had been | F | 325 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) M A. BUII | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|-------------------|------|---|-------------------------------|----------------------------|--|
| | | 295044 | | | | C 04/21/2009 | | |
| | ROVIDER OR SUPPLIER | NEVADA | • | 1950 | T ADDRESS, CITY, STATE, ZIP CODE BARING BLVD RKS, NV 89434 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 325 | Continued From pag | ge 18 | F | 325 | | | | |
| | have large weight flut to the facility. He reweight was checked renal failure. The dietitian was int AM, and reported the Resident #2 had been had completed a dies she reported that she information on Resident she routinely with the routinely with the review of the facility procedures revealed 2008, titled: "Subject: Referrals the Procedures: 6. At his or her next registered dietitian (nutritional assessment signed and the review of the patient additional recomment. Review of "The Ren Dialysis Care Within End Stage Renal Dialogo (Page 15) 4.4: "The recommended the in assessment be commended the in a service weight and in the recommended the in assessment be commended the in assessment be commended the in a service weight and in the recommended the in assessment be commended the in a service weight and in the recommended the in assessment be commended the in a service weight and in the recommended the in a service weight and in the recommended the in a service weight and in the recommended the in a service weight and in the recommended the interest and in the recommended the interest and in the recommended the interest and interest | orted that the resident did not actuations prior to admission ported that the resident's frequently at home due to his erviewed on 4/9/09 at 11:30 at she was aware that en losing weight and that she etary consult for the resident. He did not write any dent #2's medical record, but exites updates on the initial ecord. She reported that she ethis one." It's nutrition policies and the following policy dated to the Registered Dietitian facility visit, facility's RD) will (a) complete the ent or (b) document his her Nutrition Services Director's extresident status and indicate and attorn as appropriate." al Network, Inc., Delivery of the Long Term Care Facility, sease Special Study," dated the following industry Technical Expert Panel | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | ULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 295044 | B. WIN | IG | | | C 1/ 2009 |
| | COVIDER OR SUPPLIER | IEVADA | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | 04/2 | 172003 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY) | | D BE | (X5) COMPLETION DATE |
| F 325 | many patients and the Review of "Nutrition a Lippincott Sixth Edition the following industry" "Table 16-13 Role of Dialysis Patients Multiple diet parametroptimal nutritional head calories, protein, sodi calcium, and phosphorindividualized nutriem nutritional intervention accepted by the patient Peritoneal Dialysis -"Fluid restrictions are peritoneal dialysis. Parecognize significant (adjusted edema-free Discuss actions to be | to the short length of stay of eir high level of acuity." and Diagnosis Related Care," on, Copyright 2008, revealed standards: If the Dietitian in Care of ers are necessary to provide alth, including monitoring of ium, fluid, potassium, | F | 325 | | | |
| F 441 SS=G | The facility must esta infection control prografe, sanitary, and co to prevent the develo disease and infection an infection control prinvestigates, controls the facility; decides w isolation should be appropriate to the same and infection control prinvestigates. | blish and maintain an ram designed to provide a smfortable environment and pment and transmission of . The facility must establish rogram under which it , and prevents infections in that procedures, such as | F | 441 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 205044 | | | | С | |
| NAME OF PR | ROVIDER OR SUPPLIER | 295044 | | | REET ADDRESS, CITY, STATE, ZIP CODE | 04/2 | 1/2009 |
| | TONE OF NORTHERN N | EVADA | | 1 | 1950 BARING BLVD SPARKS, NV 89434 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 441 | Continued From page corrective actions relations | | F | 441 | i | | |
| | procedure review, and facility failed to prevent transmission of disease | ecord review, policy and d industry standards, the nt the development and se and infection related to 2 of 7 sampled residents | | | | | |
| | Findings include: | | | | | | |
| | Resident #2 | | | | | | |
| | disease, failure to thri atherosclerosis, cong fibrillation, anemia, ar resident's legal repres performing peritoneal | es including end stage renal ve, coronary estive heart failure, atrial nd hypothyroidism. The sentative had been dialysis for the resident in years, without the resident | | | | | |
| | resident assessment 4. Cognitive skills for | • | | | | | |
| | checked: "Alert, mem staff names/faces, that decision making - ind | 09, with the following boxes ory recall - current season, at he was in a nursing home; | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | LTIPLE CONSTRUCTION | . , | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|--|--|-------------------------------|--|
| | | 295044 | B. WING | | | C 21/2009 | |
| | ROVIDER OR SUPPLIER | IEVADA | | STREET ADDRESS, CITY, STATE, ZIF 1950 BARING BLVD SPARKS, NV 89434 | • | 172000 | |
| (X4) ID PREFIX TAG | | | ID PROVIDER'S PLAN (PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO DEFICIE | | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 441 | nursing home; decision Record review reveal note dated 1/19/09 the peritoneal catheter." Record review reveal been transferred to a 3/7/09, for coughing a On 4/6/09 at 10:30 A was interviewed and the facility contacted notify him that the resignating to take his mareported that the resignaturation of 74% and in the morning on 3/7 nurse had stated to he condition had deterion asked him if he would hospital. The resider that he directed the nuthat follows the resideral failure. He then reposavare that the resideral involved with the resideral involved with the resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. The resideral facility emergency dereportedly called a didetermine whether on the hospital. | ed a physician's progress at read: "Abdomen: normal," ed that Resident #2 had a cute care facility on and hypoxia. M, Resident #2's son-in-law reported that a nurse from him on 3/6/09 at 8:00 AM, to sident was coughing and ledications. The son-in-law dent had become evernight, with an oxygen dent that the resident's rated and that the nurse had allike her to send him to the lit's son-in-law then reported urse to call the nephrologist ent for treatment of his renal red that the nurse was not not had a nephrologist dent's care. The nurse then chrologist. The resident's lorted that the nurse called a was directed by the the resident to an acute care partment. The nurse then alysis nurse consultant to root to send the resident to ident's son-in-law reported alled back to ask what | F 4 | 41 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MI A. BUIL | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--------------------|---|---|---------------------------------------|--|--|
| | | 295044 | B. WIN | | | C 04/21/2009 | | |
| | ROVIDER OR SUPPLIER | EVADA | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 50 BARING BLVD PARKS, NV 89434 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | I | ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIEN | | CTION SHOULD BE COME THE APPROPRIATE | | |
| F 441 | resident to the closes reportedly passed aw review revealed a dea that the resident had of death was peritonit. Review of Resident # entries made into the the following: 2/25/09 - the psychiar resident and docume "underhydrated?" 2/26/09 - "Patient confluids Increased ap distension" 2/27/09 - "the resident temperature" 3/6/09 - "Resident ag chest x-ray ordered to loss 31 pounds" 3/7/09 - "Resident ag and oriented to self, s and oxygen saturation labored breathing; se evaluation." No evidence was found to contacted the physicial Resident #2's condition evidence was found to physician had been a impression on 2/25/09 | nat he told her to send the thospital. The resident ay on 3/11/09. Record ath certificate that reported expired and that the cause is. 2's medical record revealed nurse's notes that contained trist did a consult with the need that the resident was attinues to not eat takes some ical rate, abdominal thad an elevated attated; resident coughing, or rule out pneumonia; weight attated, yelling for help; alert kin pale; breathing labored in 74%; skin ash color with an to emergency room for and that the nursing staff had an related to a change in on prior to 3/7/09. No hat the resident's primary ware of the psychiatrist's 9. | F | 441 | | | | |
| | #2 that was develope | | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BUII | | | | c | |
| | | 295044 | B. WIN | G | | 04/2 | 1/2009 | |
| | ROVIDER OR SUPPLIER | EVADA | | 195 | ET ADDRESS, CITY, STATE, ZIP CODE 0 BARING BLVD ARKS, NV 89434 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 441 | on treatment days. 2. Resident will be prinot in the facility at m 3. Avoid taking blood injections over shunte 5. After dialysis treatmedverse reactions to a shunt, was not transpection dialysis was performed as the shunt, was not transpection was performed as the shunt, was not transpection of the shunt, was not transpection of the shunt, was not transpection of transpection of transpection of transpection of transpection of transpection of the shunt | ensported to dialysis center povided with take out meals if ealtimes. pressures or giving ed arm. nent observe resident for treatment." ed that Resident #2 had no orted out, as his peritoneal ed at the facility. Initted to the facility on es including end-stage renal itoneal dialysis, diabetes al vascular disease. The ent for all peritoneal dialysis ed a document titled "that was completed upon ion on 3/18/09 that read: s: temperature - 98.0 ssessment: ndependent in decision is being e." | F | 441 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 295044 | B. WIN | IG | | 1 | C 1/2009 | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA | | | 1 | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1950 BARING BLVD SPARKS, NV 89434 | | | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPRIDEFICIENCY) | N SHOULD BE COMPLETIC E APPROPRIATE DATE | | |
| F 441 | notes entries: 3/23/09 - "Has disorie 3/24/09 - "Resident v every 10 minutes." 3/25/09 - "Keeps on ishoulder pain." 3/28/09 - "Medicated 3/31/09 - "Resident of Found medications in shift. Calling for help machine keeps beep Record review reveal 3/24/09 night shift: te 3/26/09 night shift: te 4/4/09 night shift: te 4/4/09 night shift: te 1/26/09 night shift: te 1/20/09 - 3/26/09: "Pe 1/20/09 - 3/26/09: "Pe 1/20/09 - 4/2/09: "Act 1/20 | entation at times." ery needy, on the call light moaning, complains of for pain in left shoulder." ifficult today. Not compliant. his bed. Restless early constantly. Dialysis ing." ed the following: mperature - 99.4 Fahrenheit mperature - 99.1 Fahrenheit mperature - 99.1 Fahrenheit perature - 99.1 Fahrenheit ed the following entries into weekly summary: atient has been ill ts effort towards his but the day and tries his best rgitate onto his caregivers." ively participated in three of o bilateral shoulder pain." ed no evidence that the hade aware of Resident #3's | F | 441 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|--|-------------------------------|----------------------------|--|
| | | | | B. WING | | С | |
| | | 295044 | | | 04/2 | 1/2009 | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA | | 19 | REET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD SPARKS, NV 89434 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F 441 | community page | | F 441 | | | | |
| | draining of cloudy dia | llysate. | | | | | |
| | | hysician's progress note ed: "had vomiting after | | | | | |
| | I . | | | | | | |
| | revealed that on 4/5/0 department physician "Assessment: 1. Sepsis, source per associated pneumoni Emergency Departments." | recorded: ritonitis versus health care ia. | | | | | |
| | | ed that Resident #3 was still ute care facility on 4/20/09. | | | | | |
| | that almost all of the completed training re She reported that the | at 11:00 AM, and reported registered nurses (RNs) had lated to peritoneal dialysis. If acility had a consultant center come in and train the | | | | | |
| | 1 | s consultant's training outline mmended that staff not wear e peritoneal dialysis | | | | | |
| | On 4/9/09 at 11:40 A was interviewed, and | M, the dialysis consultant reported that he did | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|---|---------------------------------|-------------------------------|--|
| | | 295044 | B. WING | | 04/ | C 04/21/2009 | |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA | | | S | STREET ADDRESS, CITY, STATE, ZIP COI 1950 BARING BLVD SPARKS, NV 89434 | • | 2172003 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 441 | peritoneal dialysis propowder in the gloves peritonitis. When ash be performed using a "no, it is a clean proc." The DON reported the peritoneal dialysis procedure interviewed and repoinstructed not to wear inside of the gloves we peritonitis. Record review reveal were wearing gloves dialysis procedures. Review of the facility revealed a policy and titled: "Nursing Stand Dialysis, Peritoneal (constructed by a physicial requiring peritoneal dialysis procedures. 1. The qualified nursi ordered by a physicial requiring peritoneal dialysis and health. 2. The qualified nursi (corporate) guidelines and health. 3. The health care ce Acknowledgement of #FFNP006 | f not wear gloves during the ocedures because the was a common source of ked if the procedures were to deseptic technique, he replied edure." at she performed the ocedures on week-days. It dialysis procedures. Int Coordinator was reted that the nurses were regloves because the powder was a common cause of the dialysis procedures. It dialysis procedures that staff while performing peritoneal of procedure dated 2004, lards of practice, Subject: CAPD)," indicated: Ing staff will provide care as an for patients/residents lialysis that allows them to the practicable level of function on staff will follow the | F 44 | 41 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 295044 | B. WIN | IG | | | 2 |
| NAME OF PROVIDER OR SUPPLIER HEARTHSTONE OF NORTHERN NEVADA | | | | 19 | EET ADDRESS, CITY, STATE, ZIP CODE 950 BARING BLVD PARKS, NV 89434 | 04/2 | 1/2009 |
| (X4) ID PREFIX TAG | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 441 | essential to prevent the which often may prevent the which often may prevent the which often may prevent treatment modality. Staff who provide car training so they possed before providing perither the second of the providing perither the second of the s | tices and technique are ne occurrence of peritonitis ent patients/residents from toneal dialysis as a e must receive specialized ess advanced skill levels oneal dialysis. Tile gloves In needed to determine fluid The warticle published by the palition dated 12/02, titled: Infections and Antimicrobial is Patients," revealed the | F | 441 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|-----------------------|---|---|--|-------------------------------|--|
| | | 295044 | B. WING | | C | |
| NAME OF PR | ROVIDER OR SUPPLIER | 255547 | STRI | EET ADDRESS, CITY, STATE, ZIP CODE | 04/21/2009 | |
| HEARTHS | TONE OF NORTHERN N | NEVADA | | 950 BARING BLVD PARKS, NV 89434 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE COMPLETION | |
| F 441 | Continued From page | e 28 | F 441 | | | |
| | be seen with the nake | ed eye." | | | | |
| | Complaint #21850 | | | | | |
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